HOME HEALTH/PERSONAL CARE (HHPC) MAXIMUM ALLOWABLE FEE SCHEDULE

THIS IS YOUR WISCONSIN MEDICAID MAXIMUM ALLOWABLE FEE SCHEDULE, WHICH IS IN EFFECT AS OF THE DATE OF THIS REPORT. WISCONSIN MEDICAID CERTIFIED PROVIDERS WILL BE REIMBURSED FOR SERVICES PROVIDED TO PROGRAM RECIPIENTS AT THE LOWER OF THEIR USUAL AND CUSTOMARY CHARGE, OR THE MAXIMUM ALLOWABLE FEE.

SERVICES REIMBURSED BASED ON PROVIDER SPECIFIC (CONTRACTED RATES) AND REGIONAL OR SPECIALTY BASED RATES ARE NOT INCLUDED IN THIS FEE SCHEDULE.

ALTHOUGH THE FEE SCHEDULE DOES NOT ADDRESS THE VARIOUS COVERAGE LIMITATIONS ROUTINELY APPLIED BY WISCONSIN MEDICAID BEFORE FINAL PAYMENT IS DETERMINED (E.G., RECIPIENT AND PROVIDER ELIGIBILITY, BILLING INSTRUCTIONS, FREQUENCY OF SERVICES, THIRD PARTY LIABILITY, COPAYMENT, AGE RESTRICTIONS, PRIOR AUTHORIZATION, ETC.), IT DOES CONTAIN THE FOLLOWING INFORMATION:

PROC/M1/M2/TM

PROC - THE PROCEDURE CODE RECOGNIZED BY WISCONSIN MEDICAID TO IDENTIFY THE SERVICE PROVIDED.

M1/M2 - ONE OR TWO APPLICABLE MODIFIER(S) AFFECTING REIMBURSEMENT AMOUNT.

TM - DESCRIPTIVE MODIFIER USED TO CONVEY INFORMATION FORMERLY CONVEYED BY TOS.
NOTE: IN CERTAIN INSTANCES THE MODIFIER LISTED IS BEING USED BOTH TO CONVEY INFORMATION FORMERLY CONVEYED BY TOS AND TO AFFECT THE REIMBURSEMENT AMOUNT. IN THESE INSTANCES THE MODIFIER WILL BE DISPLAYED TWICE, ONCE IN THE M1 OR M2 COLUMN AND ONCE IN THE TM COLUMN, EVEN THOUGH IT WILL ONLY BE BILLED ONCE ON THE CLAIM DETAIL.

DESCRIPTION - AN ABBREVIATED DESCRIPTION OF THE PROCEDURE CODE

PROVIDER TYPE – ALL APPLICABLE PERFORMING PROVIDER TYPES FOR THE PROCEDURE CODE. SEE TABLE I FOR A LISTING OF PROVIDER TYPES APPLICABLE TO THIS SCHEDULE.

PAC - THE PRICING ACTION CODE IDENTIFIES NON-COVERED SERVICES OR THE SOURCE AND METHOD OF PRICING THE PROCEDURE (REFER TO TABLE II).

EFFECT DATE - THE EFFECTIVE DATE OF SERVICE ON OR AFTER WHICH THE MAXIMUM ALLOWABLE FEE APPLIES.

MAX FEE - MAXIMUM ALLOWABLE FEES FOR THE PROCEDURE CODES LISTED. IF A MAX FEE IS NOT INDICATED, USE THE PAC AND TABLE II TO DETERMINE THE REASON (E.G., PAC 220 INDICATES SERVICE NOT COVERED; PAC 21J INDICATES INDIVIDUAL CONSIDERATION, ETC.).

THIS INFORMATION IS INTENDED TO HELP YOU UNDERSTAND THE WISCONSIN MEDICAID MAXIMUM ALLOWABLE FEE SCHEDULE. IF YOU HAVE QUESTIONS, PLEASE CONTACT WISCONSIN MEDICAID PROVIDER SERVICES AT: (608) 221-9883 OR (800) 947-9627*

*WHEN REQUESTING INFORMATION, PLEASE BE SPECIFIC AS TO WHICH PROVIDER TYPE YOU ARE REFERRING (I.E., NURSE SERVICE IS PROVIDER TYPE 33).

TABLE I
PROVIDER TYPES

33 - NURSE SERVICE
44 - PHYSICAL THERAPY
45 - NURSE PRACTITIONER
48 - HOME HEALTH/PERSONAL CARE DUALLY CERTIFIED PROVIDER
86 - PERSONAL CARE PROVIDER

TABLE II
PRICING ACTION CODES (PAC)

120, 220 - NON-COVERED SERVICE, NOT A WISCONSIN MEDICAID BENEFIT
170, 270 - PAID AT THE LOWER OF THE BILLED AMOUNT OR MAXIMUM ALLOWABLE FEE ACCORDING TO PROVIDER TYPE

TABLE III
MODIFIERS

MODIFIER	DESCRIPTION
TE	LICENSED PRACTICAL NURSE
TD	REGESTERED NURSE
U1	CASE COORDINATION

PROC DESCRIPTION

PROC	M1	M2	TM	PROVIDER TYPE	PAC	EFFECT DATE	MAX FEE
92507	TREAT OF SPEECH, LANG, VOICE COMMUNICATION, A/O AUDITORY PRESSING DISORDER; INDIVIDUAL						
92507		44	48		270	10/01/03	85.35
97139	UNLISTED PROCEDURE (SPECIFY)						
97139		44	48		270	10/01/03	82.67
97799	UNLISTED PHYSICAL MEDICINE SERVICE OR PROCEDURE						
97799		44	48		270	10/01/03	80.52
99504	HOME VISIT FOR PATIENTS RECEIVING MECHANICAL VENTILATOR						
99504	TD	33	44	45 48	270	10/01/03	32.21
99504	TE	33	44	45 48	270	10/01/03	21.47
99504	U1	33	44	45 48	270	10/01/03	31.52
99509	HOME VISIT FOR ASSISTANCE W/ACTIVITIES OF DAILY LIVING & PERSONAL CARE						
99509		48	86		270	10/01/03	41.56
99600	UNLISTED HOME VISIT SERVICE OR PROCEDURE						
99600		44	45	48	270	10/01/03	84.28
99600	UNLISTED HOME VISIT SERVICE OR PROCEDURE						
99600		33			270	10/01/03	84.28
S9123	NURSING CARE, IN THE HOME; BY REGISTERED NURSE, PER HOUR						
S9123		33	44	45 48	270	10/01/03	32.21
S9124	NURSING CARE, IN THE HOME; BY LICENSED PRACTICAL NURSE, PER HOUR						
S9124		33	44	48	270	10/01/03	21.47
T1001	NURSING ASSESSMENT/EVALUATION						
T1001		44	48		270	10/01/03	84.28
T1019	PERS CARE SVCS, PER 15 MIN, NOT FOR INPATIENT, HOSPITAL, NURSING FACILITY, ICF/MR OR IMD						
T1019		33	44	45 48 86	270	10/01/03	3.96
T1021	HOME HEALTH AIDE OR CERTIFIED NURSE ASSISTANT, PER VISIT						
T1021		44	48		270	10/01/03	39.71
T1502	ADMIN OF ORAL/INTRAMUSCULAR &/OR SUBCUTANEOUS MEDICATION, HLTH CARE AGENCY/PROF PER VISI						
T1502		33	44	45 48	270	10/01/03	39.71

END OF REPORT